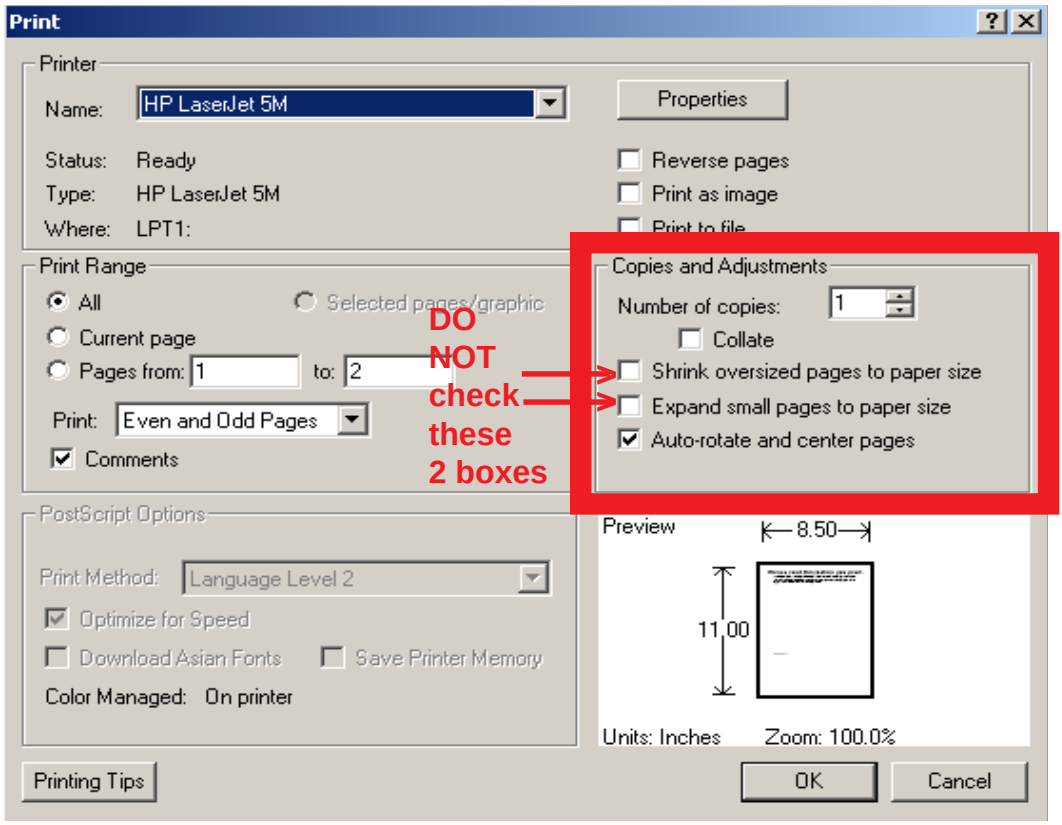
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



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Washington State Department of Health
Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Nursing Assistant Application Packet

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your *application fee is not refundable.

* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Nursing Assistant

DEPOSIT SLIP

NAME (Please Print) _____ DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$ _____

☐ **Check No. _____**
☐ **Money Order**

DOH 667-025 (REV 9/2003)

1F 0299030000 00560

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Washington State Department of Health
Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

Instructions for Nursing Assistant Registered

Complete the application fully.

You may apply for Nursing Assistant Registration by completing and submitting the following requirements:

1. Application for Nursing Assistant Registration (completed in full, front and back, in ink).
2. $15 Fee (made payable to Dept. of Health) is not refundable.
3. Verification of seven (7) hours of HIV AIDS Education.

Pay special attention to Section 3 and answer each question truthfully. If you answer yes to any question, you must include a signed and dated explanation on a separate piece of paper and copies of all judgments, decisions, orders, agreements, or surrenders. Failure to submit this documentation will delay processing your application.

Once registered you do not need to submit a new registration for each new facility in which you work. You need only renew this annually on or before your birthday.

Instructions for Nursing Assistant Certified

Individuals who wish to practice in the state of Washington as a N**ursing Assistant Certified must complete a training program** approved by the Washington State Nursing Care Quality Assurance Commission and successfully **pass the OBRA examination for certification**. This is the Federal Certification process.

For information on the OBRA (Omnibus Budget Reconciliation Act of 1987) (Federal Regulation) Registry and testing, **you must contact Department of Social and Health Services at (360) 725-2570**. (You may reach a voice mail, be sure to leave a message so they may return your call.)

You may apply for **state certification** by completing and **submitting the following requirements**:

1. **Application** for Certification as a Nursing Assistant (completed in full, front and back **in ink**)
2. **$15 Fee** (made payable to Dept. of Health) is **not** refundable
3. **Training Program Certificate** (send a copy)

Please mail the above documents to:

Department of Health
Nursing Assistant Program
PO Box 1099
Olympia, WA 98507-1099

You may contact the Department of Health at (360) 236-4700 to check on your application.

Instructions for Nursing Assistant Certified By Interstate Endorsement

If your name is listed on another state Registry, you may qualify for Interstate Endorsement as a Nursing Assistant Certified. Please complete the attached application in full and mail it with the $15.00 to:

Department of Health
Nursing Assistant Program
PO Box 1099
Olympia, WA 98507-1099

Complete the top portion of the Verification form (page 5) and send it to the state you are coming from (not Washington State). That state (the state you are coming from) will complete the Verification form and mail it directly back to Washington State.

Your application file for Nursing Assistant Certified will be completed once the following requirements have been met:

1. **$15 Fee**
2. **Application** completed in full
3. Verification from the state you are coming from that you are current on that state's Registry

If you have questions, please call (360) 236-4700.

Box 1: Demographic Information. Complete in full. A social security number is required for license under 42 USC and Chapter 26.23 RCW.

Box 2: Caregiving Employment History: Place of Caregiving Employment, first and last date of employment, and the full address of last Caregiving Employment. List the last two states where your name appears on the OBRA Registry if you are submitting application for Certified Nursing Assistant by Endorsement.

Box 3: To be completed by training Facility/School Program Director. This is required if you are applying for Certified Nursing Assistant licensure.

Box 4: Personal Data Questions: See Important Information Regarding Personal Data Questions (form 667-019) in this packet.

Box 5: AIDS Education and Training Attestation—7 hours required. Must be initialed and dated.

Box 6: Applicant's Attestation: Must be signed and dated.

HIV/AIDS Information
AIDS Education Requirements For Health Related Professions

All health related professions under the disciplinary authority of the Uniform Disciplinary Act (RCW 18.130) are affected. This requirement went into effect January 1989.

The topics that must be covered by this requirement are: ***etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality and psychosocial issues to include special population considerations.*** The course must be 7 hours or more in length.

If you feel you have not met this requirement, or you cannot document that you have, you can meet this requirement through a correspondence course or a community college. A partial listing of available offerings follows.

Robert D. Anderson Publishing Company
1-800-532-2332

Intercollegiate Center for Nursing Education
(509) 324-7356

University of Washington
(206) 543-1047

Impact Inc.
(206) 284-3865

Department of Health
AIDS Information Hot Line
1-800-272-2437
Web site: http://www.doh.wa.gov/cfh/HIV_AIDS/Prev_Edu/training.htm

New York State Nurses Association
(518) 782-9400
E-mail: info@nysna.org or web site: http://www.nysna.org

Northwest AIDS ETC
901 Boren Ave Ste 1100
Seattle WA 98104
Voicemail: (206) 221-4944
Fax: (206) 221-4945

Washington State Department of Health
Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY
CANDIDATE NUMBER
LICENSE DATE

Registration #

Certification #

Application For Nursing Assistant Credential

☐ **Registered Nursing Assistant** ☐ **Certified Nursing Assistant By Examination**
☐ **Certified Nursing Assistant By Endorsement**

Please Type or Print Clearly—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application. All applications must be accompanied by applicable fee which is **non-refundable**. Make remittance payable to the Department of Health. Individuals who wish to work in a health care facility must **register** within three days of employment with the **State of Washington Department of Health**. **A separate application is required for each profession.**

1. Demographic Information

APPLICANT'S NAME | LAST | FIRST | MIDDLE INITIAL

LIST OTHER NAMES USED

MAILING ADDRESS (MUST BE RESIDENT'S ADDRESS, **NOT** BUSINESS) | EMAIL ADDRESS (OPTIONAL)

CITY | STATE | ZIP | COUNTY

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.) ( ) | RESIDENCE TELEPHONE ( ) | SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW) — —

Birthdate (Month/Day/Year) **(REQUIRED)** | GENDER ☐ Female ☐ Male

2. Caregiving Employment History

LAST PLACE OF CAREGIVING EMPLOYMENT | FIRST/LAST DATES OF EMPLOYMENT

ADDRESS OF LAST PLACE OF CAREGIVING EMPLOYMENT

LIST THE LAST TWO (2) STATES WHERE YOUR NAME APPEARS ON THE OBRA REGISTRY

1. _____ 2. _____

3. Program Director Attestation

To be completed by Program Director or attach a copy of your training certificate.

I certify that _____ , has successfully completed
Type or Print Full Name of Applicant

the approved nursing assistant program at _____
Name of Facility/School

on _____ .
Month/Day/Year

Signature _____ Title _____

4. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

   1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

   1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

   (If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

   a. the use or distribution of controlled substances or legend drugs? ☐ ☐

   b. a charge of a sex offense? ☐ ☐

   c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceedings to have:

   a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ☐ ☐

   b. committed any act involving moral turpitude, dishonesty or corruption? ☐ ☐

   c. violated any state or federal law or rule regulating the practice of a health care professional? ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements. ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ☐ ☐

9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? ☐ ☐

5. AIDS Education and Training Attestation

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS, either through my professional education or through the completion of DSHS required training for caregivers or staff employed in DDD Certified Residential Programs, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my certification or registration may be denied, or if issued, suspended or revoked.

Applicant's Initials	Date

6. Applicant's Attestation

I, _____ , certify that I am the person described and identified in this
Name of Applicant

application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and my independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my certification or registration to practice in the State of Washington.

Signature of Applicant _____ Date _____

Official Use Only

Washington State Records Center

Washington State Department of Health
Nursing Assistant Program
PO Box 1099
Olympia, WA 98507-1099

Out Of State Verification

Mail this form to the state you are coming from. They will return it to the Washington State Department of Health.

PART I: To Be Completed By Applicant

I am listed on the Nurse Aide Registry in the state of _____ under the name of

_____ and my registration number is _____

Social Security Number _____ .

Email Address (Optional) _____

☐ I completed a nursing assistant training program at _____ (TRAINING SITE) on _____ (MO/DAY/YR) .

☐ I completed a competency examination on _____ (MO/DAY/YR)

☐ I became a nursing assistant by waiver or deeming.

☐ I am applying in Washington under the name of _____

Last recorded place of caregiving employment _____

Starting and Ending date of caregiving employment _____ (START DATE: MO/DAY/YR) _____ (ENDING DATE: MO/DAY/YR)

Address _____

*Nurse Aide: Do **not** return this form to the Washington Nurse Aide Registry. After you have completed the information requested above, it is your responsibility to send this form to the state agency from which you completed your nurse aide training and testing.*

PART II: To Be Completed By State Agency

☐ The information on this form is accurate and the above-named person is on the nursing assistant registry in our state.

☐ The above-named person is not on the nursing assistant registry in our state.

Date of Registration/Certification _____ Number _____

Expiration of Registration Certification _____

Has Registrant had any type of disciplinary action? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

_____

Is Registrant currently under investigation? ☐ Yes ☐ No

Signature _____ Date _____

Title _____ State _____

(This page intentionally left blank.)

List of Nursing Assistant State Registries

Alabama Registry
PO Box 30317
Montgomery AL 36130
334-206-5169

Alaska Registry
3601 C St #722
Anchorage AK 99503
907-269-8169

Arizona Registry
1651 E Morten #150
Phoenix AZ 85020
602-331-8111

Arkansas Registry
PO Box 8059 #402
Little Rock AR 72203
501-682-8484

California Registry
PO Box 942732
Sacramento CA 94234
916-327-2445

Colorado Registry
1560 Broadway #880
Denver CO 80202
303-894-2816

Connecticut Registry
PO Box 13785
Philadelphia PA 19101
800-274-2900

Delaware Registry
3 Mill Rd #308
Wilmington DE 19806
302-577-6666

D of C Registry
614 H St NW #1014
Washington DC 20001
202-727-7190

Florida Registry
4062 Bold Cypress Way BIN c13
Tallahassee FL 32399-3263
850-488-8401

Georgia Registry
2 Peachtree St NW 21st Fl
Atlanta GA 30303
404-657-5730

Hawaii Registry
PO Box 3469
Honolulu HI 96801
808-734-2101

Division of Medicaid
PO Box 83720
Boise ID 83720-0036
1-800-748-2480

Illinois Registry
525 W Jefferson
Springfield IL 62761
217-785-5133

Indiana Registry
PO Box 1964
Indianapolis IN 46206
317-383-6612

Iowa Registry
Lucas State Office Bldg
Des Moines IO 50319
515-281-4963

Kansas Registry
900 SW Jackson St
Topeka KS 66612
785-296-6877

Kentucky Registry
312 Whittington Pky #300-A
Louisville KY 40222
502-329-7047

Louisiana Registry
5615 Corporate Blvd #8D
Baton Rouge LA 70808
504-925-4591

Maine Registry
State House Station 158
Augusta ME 04333
207-624-5205

Maryland Registry
4201 Patterson Ave
Baltimore MD 21215
410-402-8110

Massachusetts Registry
10 West St
Boston MA 02111
617-727-5860

Michigan Registry
PO Box 30670
Lansing MI 48909
517-241-0554

Minnesota Registry
PO Box 64501
St Paul MN 55164
651-215-8705

Mississippi Registry
239 N Lamar #401
Jackson MS 39201
601-359-6399

Missouri Registry
PO Box 1337
Jefferson City MO 65102
573-751-3082

Montana Registry
PO Box 202953
Helena MT 59620
406-404-4980

Nebraska Registry
PO Box 95007
Lincoln NE 68509
402-471-0537

Nevada Registry
PO Box 46886
Las Vegas NV 89114
709-739-1575

New Hampshire Registry
6 Hazen Dr
Concord NH 03301
603-271-6282

New Jersey Registry
Health Facilities Eval
Trenton NJ 08625
609-533-7771

New Mexico Registry
525 Comino de los Marques @2
Santa Fe NM 87501
505-827-4206

New York Registry
PO Box 42480
Philadelphia PA 19101
800-274-7181

North Carolina Registry
PO Box 29530
Raleigh NC 27626
919-715-0562

North Dakota Registry
600 E Boulevard Ave
Bismarck ND 58505
701-328-2388

Ohio Registry
PO Box 118
Columbus OH 43266
614-752-9522

Oklahoma Registry
1000 NE 10th St
Oklahoma City, OK 73117
800-695-2157

Oregon Registry
800 NE Oregon St
Portland OR 97232
503-731-3459

Pennsylvania Registry
PO Box 90
Harrisburg PA 17108
717-772-3815

Rhode Island Registry
3 Capitol Hill #401
Providence RI 02098
401-277-2827

South Carolina Registry
2600 Bull St
Columbia SC 29201
803-737-7207

South Dakota Registry
4300 S Louise C-1
Sioux Falls SD 58106
605-362-2760

Tennessee Registry
283 Plus Park Blvd
Nashville TN 37247
615-532-7841

Texas Registry
PO Box 149030 Y977
Austin TX 78714
800-452-3934

Utah Registry
550 East 300 South
Kayville UT 84037
801-547-9947

Vermont Registry
109 State St
Montpelier VT 05609
802-828-2819

Virginia Registry
6606 W Broad St 4th Fl
Richmond VA 23230
804-662-7310

Washington Registry
PO Box 45600
Olympia WA 98504
360-438-7925

West Virginia Registry
1900 Kanawha Blvd E #3
Charleston WV 24305
304-558-0050

Wisconsin Registry
PO Box 2569
Madison WI 53101
608-267-2374

Wyoming Registry
2301 Central Ave
Cheyenne WY 82002
307-777-7601

Washington State Department of Health
Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

Nursing Assistant Registry Verification Websites

Colorado:
http://www.dora.state.co.us/pls/real/ARMS_Search.Disclaimer_Page

Delaware:
http://www.hdmaster/com/

District of Columbia:
http://www.asisvcs.com/services/registry/search_generic.asp?CPCat=0709NURSE

Idaho:
http://www.hdmaster.com/

Illinois:
http://app.idph.state.il.us/nar/index.htm

Michigan:

https://appserv01.chauncey.com/Accelerator/FlowMgr.srv?cmd=validateLogin&sourceFunction=9000&sourceScreen=0&sourceSequence=10&userName=mifoia&password=password

Mississippi:
http://www.asisvcs.com/services/registry/search_generic.asp?CPCat=0725NURSE

New Jersey:
http://www.asisvcs.com/services/registry/search_generic.asp?CPCat=0631NURSE

North Carolina:
http://www.ncnar.org/verify_listings.shtml

Oregon:
http://mscfprod1.iservices.state.or.us/nursinglu/LicenseLookup.cfm

Pennsylvania:

http://www.asisvcs.com/services/registry/search_fs.asp?CPCat=0639NURSE

South Carolina:
http://www.asisvcs.com/services/registry/search_generic.asp?CPCat=0741NURSE

West Virginia:
http://www.wvdhhr.org/ohflac/nurseaide/nalookup/NALookup.asp

Wisconsin:
http://www.asisvcs.com/services/registry/search_generic.asp?CPCat=0750NURSE

Washington State Department of Health
Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

Important Information Regarding Personal Data Questions

This page contains important questions and answers concerning the personal data questions. You will be held responsible for this information.

1. **For questions 5a, 5b and 5c, do I need to reveal a conviction that is over three years or over five years old?**

   Yes, this question asks if you have **ever** been convicted, etc. of any crime other than a minor traffic violation.

2. **For questions 5a, 5b and 5c, do I need to reveal a conviction that is not a felony?**

   Yes, you must reveal all convictions even if they were a misdemeanor or seem minor. The only exception to this is minor traffic infractions. You must, however reveal a DUI or a Reckless Driving Conviction.

3. **But I've been told that I don't need to reveal certain crimes if it's been over a certain amount of time or that I don't need to reveal any crimes not on the "List of Disqualifying Crimes".**

   That information is incorrect. Be aware that this "Disqualifying Crimes" for the Department of Social and Health Services **does not apply** to this application with the Department of Health.

4. **What is the difference between the Department of Social and Health Services and the Department of Health?**

   The Department of Social and Health Services ensures that a nursing assistant meets Federal requirements to work in a Nursing Home. The Department of Health makes sure a Nursing Assistant meets additional state requirements to work in any setting. The laws each Department follows are different. This is why the DSHS disqualifying list does not apply to the Department of Health's criteria.

5. **What happens if I answer" no" to a question I should have answered "yes" to?**

   The Department of Health can issue an "Intent to Deny" your application for registration or certification based on a deceptive answer. You will have the chance to respond and, if necessary, go to a hearing regarding this matter. Be aware that this process can be quite lengthy.

   If you are granted a registration and/or certification based on deceptive answers to the personal data questions and the Department later finds out about this, disciplinary action can be taken against your registration and/or certification at that point in time. This means your credential could be revoked based on inaccurate information on your original application.

6. **Do I need to send documentation when I answer "Yes" to questions 5, 6, 7, 8 or 9?**

   Yes, you must provide a signed and dated statement of explanation and copies of all judgements, decisions, orders, agreements or surrenders. **If you do not send this documentation with your application, it will delay the processing of your application.**

7. **What if I am convicted of a crime after I submit my application and/or receive my registration/ certification?**

   You are required by RCW 18.130.070 (4) to report any conviction, determination or finding that you have committed unprofessional conduct or are unable to practice with reasonable skill and safety.

If you do not understand the above information, please contact the Department of Health at (360) 236-4700.